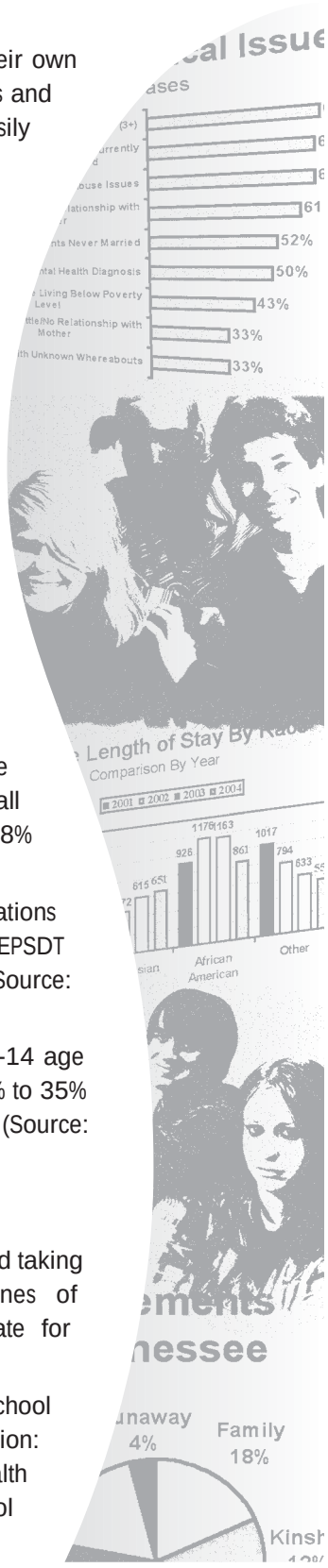
Summary Chapter XI

Youth Access to Health Care

Adolescence is a time when youth begin making independent choices concerning their own health and health care. Their experiences will have lifelong effects on their health choices and adult health status, so it is important that the care they receive is timely, appropriate, easily accessible and affordable.

Health insurance is vital to adolescents' access to and use of health care services. Children not covered by health insurance are less likely than those with health insurance to have a regular source of health care and less likely than the privately insured to have used prescription medicines. Children without health insurance are more likely than others to receive late or no care for health problems, putting them at greater risk for hospitalization. In addition to less access to health care, a lack of health insurance can influence children's school attendance and participation in extracurricular activities, and has been shown to increase parental financial and emotional stress.



Tennessee Data

More than one in 17 Tennessee children is not insured.

- According to 2002-2003 state data, 31% of Tennessee's children ages 18 and under are enrolled in Medicaid. This compares to 27% nationally.
- About 134,710 (9%) Tennessee children ages 18 and under are uninsured.
- 81,000 children or 5.6% of all children under age 19 whose families are at or below 200% of the poverty level are without insurance in Tennessee.
- The number and percent of children in Tennessee without health insurance has more than doubled from 2000 to 2004. In 2000 there were 71,561 children (4.9% of all children in Tennessee) without health insurance. By 2004 there were 173,220 (10.8% of all Tennessee children) without health insurance.
- The percentage of children who have received complete EPSDT annual examinations increased substantially from 2001 to 2004. In 2001, 38% received complete EPSDT annual examinations. By FY 2003-2004 the number had increased to 67.2%. (Source: TennCare Bureau, EPSDT Program)
- As children age, the percentage of EPSDT screenings decreases except for the 10-14 age group. Based on 2003 data, after age 5, the percent of screenings drops from 79% to 35% for ages 6-9, 39% for ages 10-14, 34% for ages 15-18, and 28% for ages 19-20. (Source: CMS Annual EPSDT Participation Report, Form 416, Tennessee, 2003)

Best Practices

- ***Parents*** – Strategies for parents include making preventive health care a priority, and taking children for regular check-ups and immunizations; establishing open lines of communication with adolescents to talk about health; and being an advocate for adolescent health at school and in the community.
- ***Schools*** – Schools can support student health by working on the eight coordinated school health school components identified by the Centers for Disease Control and Prevention: health education, physical education, health services, nutrition services, health promotion for staff, counseling and psychological services, healthy school environment and parent/community involvement. Schools can also institute a

program of health instruction for students and serve as hosts for community providers to locate their physical and mental health services within school walls.

- **Community Health Care Providers** – Providers can make their services "teen friendly" by promoting regular preventive health visits; seizing health promotion opportunities; ensuring access to primary caregivers with skills, experience and interest in adolescents; offering comprehensive screening and counseling for high-risk behaviors; protecting the confidentiality of their teen patients; and teaching parents and other caring adults how to support adolescent well-being.

2✪1✪ Objectives

Reduce Uninsurance Rates

By 2010, reduce the percent of children without health insurance to 7%, from the 2004 baseline of 10.8%.

Increase Access to Health Care Services

By 2010, increase the percentage of children with complete EPSDT annual examinations to 80% from the 2003/2004 baseline rate of 67.2%.

Websites

American Academy of Pediatrics
www.aap.org

Annie E. Casey Foundation
www.aecf.org

Association of Maternal and Child Health Programs
www.amchp.org

Bright Futures
www.brightfutures.org

Center on Budget and Policy Priorities
www.cbpp.org

Center for Health and Health Care in Schools
www.healthinschools.org

Center for Health Services Research and Policy
www.gwhealthpolicy.org/chsrp

Center for Law and Social Policy
www.clasp.org

Center for Reproductive Rights
www.crlp.org

Children Now
www.childrennow.org

The Commonwealth Fund
www.cmwf.org

Covering Kids
www.coveringkids.org

Future of Children
www.futureofchildren.org

Kaiser Commission on Medicaid and the Uninsured
www.kff.org

National Adolescent Health Information Center
http://nahic.ucsf.edu/

National Assembly on School-Based Health Care
www.nasbhc.org

National Center for Education in Maternal and Child Health
www.ncemch.org

National Center for Health and Health Care in Schools
www.healthinschools.com

National Center for Youth Law
www.youthlaw.org

National Conference of State Legislatures
www.ncsl.org

National PTA
www.pta.org

Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.ncjrs.org

Policy Information and Analysis Center for
Middle Childhood and Adolescence
http://policy.ucsf.edu/

Society for Adolescent Medicine
www.adolescenthealth.org

Urban Institute
www.urban.org

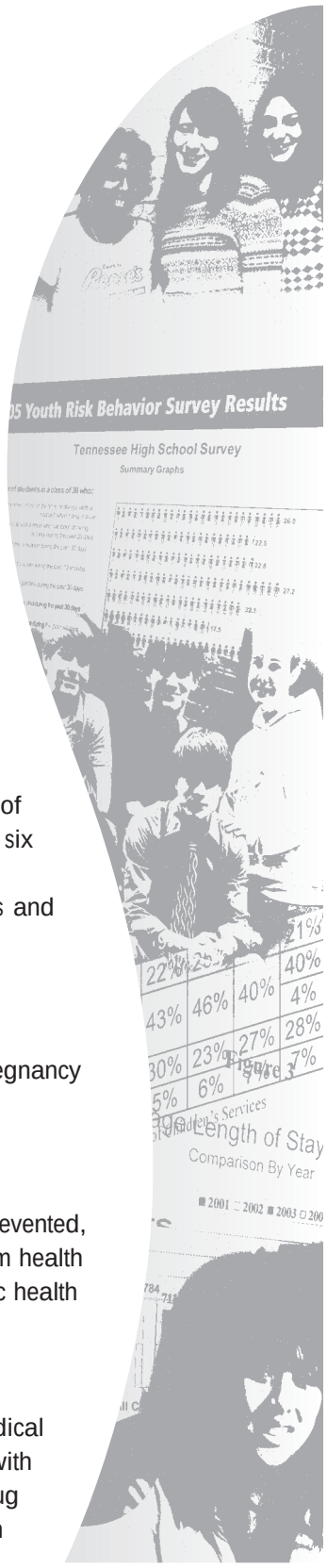
Chapter XI

Youth Access to Health Care

Chapter Preview

This chapter includes a description of:

- The importance of youth accessing health care
- Confidentiality laws
- TennCare and EPSDT programs
- National and state data
- Best practices
- State health care access programs



Adolescence is a time when youth begin making independent choices concerning their own health and health care - physical, mental and dental. Their experiences can have lifelong effects, so it is important that the care they receive is timely, appropriate, easily accessible and affordable.

Because most adolescents are generally physically healthy, we tend to take their health for granted. However, adolescent health concerns include skin conditions, weight and nutrition, vision concerns,[1] dental and orthodontia concerns, conditions of the spine, reproductive issues,[2] common viral diseases such as infectious mononucleosis and meningitis and access to immunization services.[3] They also commonly need services for mental health, substance abuse and social development issues.

Health promotion and injury prevention services are critical during this phase of development. Most premature death and illness in the United States is related to six categories of behavior:

- Behavior resulting in unintentional or intentional injury (including suicide attempts and completions)
- Use of alcohol and other drugs
- Tobacco use
- Sexual behaviors contributing to sexually transmitted infections and unintended pregnancy
- Inadequate physical activity
- Poor dietary habits

These behaviors are commonly initiated during adolescence. Unfortunately, if not prevented, these behaviors often extend into adulthood and have serious consequences for long-term health status. Virtually every early death in adolescence is preventable, and many adult chronic health conditions find their genesis in these preventable adolescent risk behaviors.[4]

Prevention Pays

Health economists estimate that every year the US spends $33.5 billion on direct medical cost (e.g., hospital, doctor care, and drugs) for preventable adolescent illness associated with just six areas: teen pregnancy, sexually transmitted infections, alcohol and other drug problems, motor vehicle injuries, other unintentional injuries and outpatient mental health

visits. These experts also estimate that it would cost only about $4.3 billion (or $203 per person) annually to provide adolescents and young adults (ages 10-24) with a comprehensive package of health and dental services such as that recommended by the American Academy of Pediatrics.[5]

If adolescents have a regular source of health care ("medical home") they are more likely to receive preventive services. A medical home, as opposed to an emergency room, is a place where a person forms a relationship with a health provider and feels comfortable enough with the health care system to access care in a timely and appropriate manner.[6] Because teens are changing so rapidly in their physical, social and emotional development, health experts recommend that adolescents (up to age 21) have an annual, routine preventive visit.[7] These regular visits to a health practitioner are opportunities to detect potential health problems early on, especially if there is a family history of poor health or chronic disease. Equally as important, they offer opportunities for preventive counseling to the adolescent and his or her family.

However, adolescents are the group of children who are least likely to be insured and most likely to "under use" primary and preventive health services. They face substantial barriers in entering and using the health care system, often missing opportunities to improve their health. The major barrier is cost. Other factors impeding access include geography and lack of transportation, a shortage of providers trained in adolescent specialties and limited provider participation in subsidized care.[8]

Health Insurance - The Key to Health Care Access

Health care is expensive; without health insurance (public or private) youth are much less likely to receive health services in a medical home. Thus, health insurance is vital to adolescents' access to and use of health care services. Children not covered by health insurance are less likely than those with health insurance to have a regular source of health care and less likely than the privately insured to have used prescription medicines.[9] Children without health insurance are more likely than others to receive late or no care for health problems, putting them at greater risk for hospitalization.[10]

In addition to less access to health care, a lack of health insurance can influence children's school attendance and participation in extracurricular activities, and has been shown to increase parental financial and emotional stress.[11]

National Data

Based on 2003 data, 89% of all children have some kind of health insurance. Most children (66%) are covered by private health insurance; 29% are covered by government health insurance.[12]

More non-Hispanic white children (93%) have health insurance compared to Asian/Pacific Islander (88%), African-American (86%) and Hispanic (79%).[13]

Family income affects the likelihood of health insurance coverage: families making less than $25,000 have 82% covered, families making $25,000 – $49,999 have 86% covered, families making $50,000 – $74,999 have 92% covered and families making $75,000 or more have 95% covered.[14]

Citizenship is also a telling variable: 90% are covered if native-born citizen, 85% are covered if naturalized citizen, and 59% are covered if foreign-born non-citizen.[15]

As children age, they lose health insurance coverage. In 2003, 90% of children ages 0-5 were covered, ages 6-11 - 89% are covered, and ages 12-17 – 87% have health insurance. Trends have stayed steady since 1987. However, there has been a significant increase in government supplied insurance (19% to 29%) and a decrease in private insurance coverage (74% to 66%) during this same time period.[16]

Tennessee Data

- More than one in 17 Tennessee children (134,710) are not insured.[17]
- According to 2002-2003 state data, 31% of Tennessee's children ages 18 and under are enrolled in Medicaid. This compares to 27% nationally.[18]
- About 134,710 (9%) Tennessee children ages 18 and under are uninsured.[19]
- 81,000 children or 5.6% of all children under age 19 whose families are at or below 200% of the poverty level are without insurance in Tennessee.[20]
- The number and percent of children in Tennessee without health insurance has more than doubled from 2000 to 2004. In 2000 there were 71,561 children (4.9% of all children in Tennessee) without health insurance. By 2004 there were 173,220 (10.8% of all Tennessee children) without health insurance.[21]
- The percentage of children who have received complete EPSDT annual examinations increased substantially from 2001 to 2004. In 2001, 38% received complete EPSDT annual examinations. By 2003/2004 the percentage had increased to 67.2%.[22]
- As children age, the percentage of EPSDT screenings decreases except for the 10-14 age group. Based on 2003 data, after age 5, the percent of children receiving EPSDT screenings drops from 79% to 35% for ages 6-9, 39% for ages 10-14, 34% for ages 15-18, and 28% for ages 19-20.[23]

Table 1 describes the distribution of Tennessee children 18 and under by insurance status. Employer sponsored insurance (55%) is the most frequent type of insurance coverage followed by Medicaid which in Tennessee is called TennCare (31%).

TennCare - Medicaid Comprehensive Health Coverage for Children

TennCare is a statewide program to provide health care benefits to Medicaid beneficiaries, uninsured State residents with income below specified limits and uninsured residents at any income level if they have medical conditions that make them uninsurable. All health care services are provided through a managed care approach with health maintenance organizations (HMOs) providing for medical services, behavioral health organizations (BHOs) providing for mental and substance abuse services, a dental benefit manager (DBM) providing for covered dental services, and a pharmacy benefit manager (PBM) providing for pharmacy services.[24]

As part of the Balanced Budget Act of 1997, Congress created Title XXI, the State Children's Health Insurance Program (SCHIP), to address the growing problem of children without health insurance. SCHIP was designed as a Federal/State partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. In Tennessee, the SCHIP program was combined within the existing TennCare program.

As of June 20, 2004, there were 234,951 children ages 6-13 enrolled on TennCare, 128,342 children ages

Table 1

Distribution of Children 18 and Under by Insurance Status, State Data 2002-2003, U.S. 2003

Insurance Source	Tennessee	United States
Employer	55%	57%
Individual	5%	4%
Medicaid	31%	27%
Uninsured	9%	12%

Source: Kaiser Family Foundation, State Health Facts, Tennessee: Distribution of Children 18 and Under by Insurance Status, state data 2002-2003, U.S. 2003. web site www.statehealthfacts.org

14-18 and 43,080 ages 19-20. The total number of children and youth ages 6-20 on TennCare was 406,373. Of this group, the majority of children and young adults were white (59%) followed by African-American (36%), "other" (4%), and Hispanic (2%).[25]

EPSDT (TENNderCARE)

Also, within TennCare, the Early Periodic Screening, Diagnosis and Treatment (EPSDT) service is provided. EPSDT is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. For more in depth information, access Tennessee's TENNderCARE (EPSDT) website at http://www.state.tn.us/tenncare/tenndercare/index.html.

Screening Services

Screening services include 7 components:

1) Comprehensive health and developmental history.
2) Comprehensive unclothed physical exam.
3) Appropriate immunizations (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines).
4) Laboratory tests including lead toxicity screening - All children are considered at risk and are screened for lead poisoning at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test is used when screening Medicaid-eligible children.
5) Health Education - Health education is a required component of screening services and includes anticipatory guidance.

6) Vision/Dental Services - Vision services are provided according to the American Academy of Pediatrics (AAP) periodicity schedule. A direct dental referral is required for every child starting at age 3 or as indicated earlier in accordance with the AAP periodicity schedule.
7) Hearing Screening – Hearing screenings are providing according to the AAP periodicity schedule.

Diagnosis

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services are provided.

Treatment

Health care is available for treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services.[26]

Accessing Health Care Services

Barriers to accessible health care for youth primarily revolve around outreach, income-related eligibility, a shortage of providers, lack of comprehensive services, developmental appropriateness of services and confidentiality.

Outreach

Although enrollment of adolescents has increased in health insurance programs, local providers and advocates must make special efforts to reach adolescents. Certain barriers persist.

While outreach targeted in schools has met success, many adolescents are not in school. Targeted outreach is needed to teens with special health care needs, teens in alternative education, home-schooled teens, juveniles being released from incarceration, adolescents in foster care and homeless or runaway youth.

In response to the need to provide more preventive care to Tennessee's children and youth, the Bureau of TennCare requested that the Tennessee Department of

Health implement TENNderCARE, an EPSDT outreach program designed to encourage parents of children and youth, ages birth to 21, to take advantage of free health screenings for their children.

One component of the outreach program is a community initiative utilizing health educators and lay community outreach workers. Health educators are working with other agencies in the community to increase the knowledge of TennCare recipients about the need for preventive care for their children. Lay community workers use a peer approach to educating TennCare recipients about preventive care. All of the community staff participate in community events.

The second outreach component is a TENNderCare Call Center, located in Nashville. Call center operators provide individualized outreach to families of newly enrolled TennCare children and newly re-certified TennCare children. Parents are provided education on the importance of TENNderCare services and advised that the cost of these services is covered by TennCare. With agreement of the parent, the operator contacts the member's primary care provider (PCP) and makes an appointment for the child. If the PCP's office is open at the time of the call, the operator initiates a conference call between the member, the PCP office and the operator. If it is after hours, the operator calls the PCP's office on the next business day and follows-up with the member. The operators also help parents make appointments for transportation services, if needed.[28]

From January–June 30, 2005, 8,705 children were contacted by outreach staff. Another 22,912 adults and youth were contacted through coalition meetings, outreach projects/events and other community presentations.[28]

Enrollment/Eligibility

Eligibility for TennCare depends primarily on family income and age of the child. As of July 2005, low income pregnant women and children up to age 19 qualify if their monthly income limit is:

- Pregnant women and infants to age 1: 185% poverty ($2,481 for a family of 3)
- Children from age 1 to age 6: 133% poverty ($1,784 for a family of 3)
- Children from age 6 to age 19: 100% poverty ($1,341 for a family of 3)

Coverage for the uninsured is closed except for children under age 19 who are leaving Medicaid and who meet the uninsured criteria of no access to insurance through one's job or a family member's job and whose family meets the monthly income limits.

Effective April 29, 2005, the medically eligible category is closed except for children under age 19 who are leaving Medicaid and who meet the Medically Eligible Criteria. These young people must apply for TennCare Standard and have been determined by the state or a state-contracted underwriter to be unable to purchase health care insurance in the private market because of health conditions.[29]

Given the numerous changes to the TennCare program, it is suggested that TennCare's website be accessed for the most up to date information (www.state.tn.us/tenncare).

Shortage of Providers

Medicaid reimbursements in Tennessee are still low relative to the real cost of delivering care, and some communities in Tennessee do not have an adequate number of health care providers who will accept TennCare patients.

Health Department Services

During fiscal year 2004-2005 there were 232,739 youth and young adults ages 10-24 who received services through local public health department clinics. 18.31% were ages 10-14, 39.37% were ages 15-19 and 42.32% were ages 20-24. Of these youth and young adults, 29% of all 10-14 year olds were seen through the Child Health program followed by TennCare Advocacy (15%), Dental (12%), and Birth Certificates (10%). For youth ages 15-19, most frequent public health services used included Child Health (14%), TennCare Advocacy (12%), Family Planning (12%), WIC (10%), and Birth Certificates (10%). For young adults ages 20-24, the most frequent service used was WIC (17%) followed by TennCare Advocacy (10%), Family Planning (10%), STDs (9%) and Women's Health (9%). [30]

Comprehensive Services

Insurance benefit packages should include elements critical for adolescent health care, such as coverage for preventive medical, dental, mental health or substance abuse care and treatment. Because adolescent physical health problems often are intertwined with behavioral

issues, services must provide counseling for prevention and be coordinated with and linked to follow-up care.[31]

Confidentiality

Numerous studies document that many adolescents are reluctant or unwilling to seek medical care without the assurance of confidentiality. In a recent national survey of almost 7,000 adolescent girls, nearly one-third had missed a medical appointment for needed care. "Not wanting a parent to know" was the most common reason for missing care for both girls and boys. Adolescents may seek confidentiality as part of the normal process of developing autonomy, from a desire for maturity, as a way to protect reputation or self-esteem, or due to fear of hostile or abusive reactions from parents.[32]

Both initial consent for care and subsequent notification of care having been given raise concerns about confidentiality.

State legislatures engage in a complex balancing act. The rights of parents to make health decisions for their children are balanced against the public health benefit of facilitating adolescents' confidential access to health care, especially for sensitive services. If adolescents delay access to services out of fear of parent notification, they may jeopardize their own health and health of others. On the other hand, parental involvement may be beneficial and facilitate ongoing attention to an adolescent's health problems.[33]

In Tennessee, there is no "one law fits all ages" guidance with regard to parental consent, notification or confidentiality for adolescents. Different subjects are treated individually. (See Appendix D for a chart of Tennessee's Minor Consent Laws)

Minor parents

A minor who is a parent may give consent for medical treatment for their minor child if recommended by a licensed physician (TCA 63-6-229).

Contraceptive services.

Tennessee law permits adolescents access to "all medically acceptable contraceptive procedures, supplies and information" regardless of age or marital status (TCA 68-34-104).

Prenatal care.

Tennessee law permits minors access to prenatal care without parental consent (TCA 63-6-223).

Access to sexually-transmitted disease (STD) services, including human immune-deficiency virus (HIV).

Minors may consent to confidential testing and treatment for STDs and HIV without the prior consent or later notification of a parent or guardian (TCA 68-10-104(c).

Parental involvement in minor's abortions.

In Tennessee, health care providers are required to get written consent from the parent or guardian of the minor before a minor may obtain an abortion (TCA 37-10-303(a). However, the minor may petition the court to seek a waiver of this provision (TCA 37-10-303(b). If a criminal charge of incest is pending against a parent, then consent is not required (TCA 37-10-303(c).

Tattooing and piercing.

Body art or piercing requires prior parent or legal guardian written consent before being performed on a minor (TCA 62-38-305).

Mental health care.

A minor 16 years or older has the same rights as an adult to receive mental health treatment (TCA 33-8-202).

Substance abuse.

Physicians can treat juvenile drug abusers without parental consent (TCA 63-6-220(a). Also, the physician can use his/her discretion in determining whether to notify the juvenile's parents of such treatment (TCA 63-6-220(b).

Best Practices for Increasing Access to Health Care

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.

This section describes some promising strategies for broadening support for improving adolescent health care. Parents, health providers, schools and organizations serving youth can work together on a "game plan" for improving adolescent health.

Parents

Strategies for parents include:

- Making preventive health care and education a priority for the family by taking children for regular check-ups and immunizations
- Establishing open lines of communication with adolescents to talk about health
- Supporting school policies on health issues
- Being an advocate for adolescent health at school, at work and in the community.[34]

Health Care Providers

Strategies for health care providers include:

- Endorsing and promoting regular preventive health visits
- Seizing health promotion opportunities
- Ensuring access to primary caregivers with skills, experience and interest in adolescents
- Encouraging the use of multidisciplinary clinical teams
- Offering comprehensive screening and response for high-risk behaviors
- Protecting the confidentiality of teen patients
- Providing services through centers that tailor their services to the unique needs of adolescents and achieve better patient participation and health outcomes
- Listening to adolescents
- Helping parents and other caring adults learn how to support adolescent well being
- Participating in community-based health initiatives
- Supporting and dissemination of research about preventive care for adolescents[35]
- Making clinics/offices teen friendly.

Schools

Schools are a natural setting in which to identify uninsured students and reach out to their families to enroll their children in TennCare. A common set of strategies has emerged:

- Incorporate outreach into regular school meetings or events
- Piggy-back on routine school mailings
- Create new referral mechanisms, using the school lunch program or emergency contact forms
- Implement presumptive eligibility, in which state-authorized entities, such as schools, can temporarily enroll children in health coverage if they appear eligible
- Enable on-site eligibility determination, in which local Department of Human Service staff members are out-stationed in the school district.[36]

At the national level, the Division of Adolescent and School Health at the National Center for Chronic Disease Prevention and Health Promotion champions these health promotion strategies for school-age children:

- Employ models where health activities, messages and services are coordinated among eight school components: comprehensive health education, physical education, health services, nutrition services, health promotion for staff, counseling and psychological services, healthy school environment and parent/community involvement.[37]
- Institute a planned and sequential program of health instruction for students in grades K through 12. Parents, health professionals and other concerned community members are involved in the design of the program. The curriculum, delivered by trained teachers, addresses a range of categorical health problems at developmentally appropriate ages. School programs include activities that help young people develop the skills they need to avoid behavior that places their health at risk.[38]

School-Based and School-Linked Services

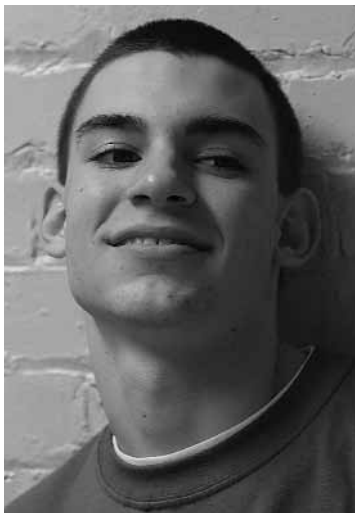
If adolescents are reluctant or unable to access health care services, why not bring the services to them? This is what school-based and school-linked health centers (SBHCs) do.

During the 1999-2000 school year, there were over 1300 school-based health centers across the United States.[39] SBHCs emphasize prevention and early intervention by offering basic medical services, mental health and substance abuse services and health promotions activities. School-based (or school-linked) health centers support the mission of schools - to help students learn. Students miss less school seeking needed health services, and are better able to concentrate when health and mental problems are resolved and under control.

Research studies have shown that SBHCs:

- Reduce the use of expensive emergency room care and reduce overall Medicaid expenditures, while increasing use of preventive well child/ adolescent services[40]
- Educate parents about the TENNderCARE (EPSDT) program, and the importance of preventive health care
- Improve immunization rates
- Reduce behavioral health risks among vulnerable students
- Help students stay in school, be promoted and graduate
- Engage a broad local community constituency in health planning for children[41]
- Play a vital role in linking students to mental health services.[42]

SBHCs in Tennessee have not experienced significant growth. According to the National Assembly on School-Based Health Care web site, 26 schools in Tennessee currently have a school-based clinic. Most of the schools with SBHCs are located in urban areas and in rural East Tennessee.[43]



Community

Enrolling Teens in Health Insurance

Despite serious efforts to enroll children in Medicaid, an estimated seven million who are eligible throughout the United States are not enrolled. Much has been learned about successful outreach strategies.[44]

- Develop innovative out-stationing of eligibility technicians in clinical and school settings.
- Use technical tools, such as software, for tracking insurance status.
- Address language and cultural differences.
- Enlist neighborhood residents and community health workers who can speak to other parents from their own experiences, and assist in outreach.
- Ensure a "user-friendly" atmosphere in places and processes for enrollment.
- Form outreach "collaboratives" among state and local agencies.
- Participate in community events.
- Use local media and marketing.
- Provide scholarships for payment of application fees and premiums.

Services Tailored to Teens

Regardless of the type of health insurance, adolescents need services that meet their particular needs. "Adolescent-friendly" care:

- Provides an appropriate mix of benefits and services.
- Assures provider competency with sexual orientation, language, culture, and appropriate developmental approaches.
- Offers teen-friendly locations and hours of operation.
- Assures confidentiality.

Adolescents are the age group least likely to use the health care system. They may not seek care voluntarily if they are uncomfortable with the provider. Many

health care providers are not trained to deal with adolescents in general, much less adolescents with health risks such as mental health, substance abuse, homelessness, sexual identity or those transitioning out of the foster care or juvenile justice systems.[45]

Adolescents often "enter" the health care system through the emergency room door, seeking care for their immediate problem. Health care providers therefore often miss the opportunity to inquire about other health-related issues.[46]

Adolescents often will only seek health care or follow-up care if the location and hours are convenient.[47]

Tennessee Health Care Access Programs

TennCare

There are two (2) types of TennCare: TennCare Medicaid and TennCare Standard.

TennCare Medicaid is for Tennesseans who are eligible for a Medicaid program, such as Families First (AFDC).

TennCare Standard is for children, under the age of 19, who have had TennCare Medicaid but their eligibility through Medicaid is ending.

TennCare Medicaid is the only way a new applicant can enroll in TennCare.

All health care services are provided through a managed care approach with health maintenance organizations (HMOs) providing medical services, behavioral health organizations (BHOs) providing mental and substance abuse services, a dental benefit manager (DBM) providing covered dental services, and a pharmacy benefit manager (PBM) providing pharmacy services. More specific TennCare information can be accessed through the TennCare website - www.state.tn.us/tenncare/.

EPSDT - TENNderCARE

EPSDT is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes early periodic screening, diagnosis and treatment services. In Tennessee, EPSDT is known as TENNderCARE.

One component of the TENNderCARE outreach program is a community initiative utilizing health educators and lay community outreach workers. The other outreach component is a TENNderCARE Call Center, located in Nashville. Call center operators provide individualized outreach to families of newly enrolled TennCare children and newly re-certified TennCare children.

End Notes

1. Health experts recommend eye exams every one to two years during adolescence because myopia (nearsightedness) generally develops during late childhood and early adolescence. K Soren, "The adolescent years," in *Complete Home Medical Guide*, 3rd rev. ed., Columbia University College of Physicians and Surgeons (1995).
2. Ibid. This includes for girls: pelvic examinations and discussions about sexually transmitted infections for sexually active girls, instruction on breast self-exams, and issues around menstruation; for boys, it includes examinations for penis and scrotum abnormalities and discussions about sexually transmitted infections for sexually active boys. For both girls and boys issues include discussions about abstinence, sexual activity and contraception.
3. Ibid. Recommended immunizations include tetanus and diphtheria booster, Hepatitis B and tuberculosis if the young person is exposed to high-risk adults. Recently there has been discussion about vaccination for college bound youth against meningitis. Maryland requires incoming college dorm students to be vaccinated for meningitis or sign a waiver declining the vaccine. California requires that colleges and universities inform students about meningococcal vaccine and document that that they have done so. Centers for Disease Control and Prevention, "Meningococcal disease and college students: Recommendations of the Advisory Committee on Immunization Practices," *MMWR* 49(RR07): 11-20 (2000).
4. Centers for Disease Control and Prevention, "Youth risk behavior surveillance – United States, 1997," *MMWR* 7(SS-03) (1998).
5. MJ Park et al., *Investing In Clinical Preventive Health Services for Adolescents*, Policy Information and Analysis Center for Middle

Childhood and Adolescence and National Adolescent Health Information Center, University of California, San Francisco (2001).

6. A Ziv, JR Boulet and GB Slap, "Emergency department utilization by adolescents in the United States," *Pediatrics* 101(6): 987-994 (1998); KM Wilson and JD Klein, "Adolescents who use the emergency department as their usual source of care," *Archives of Pediatrics and Adolescent Medicine* 154(4):361-365 (2000); S Ryan et al., "The effects of regular source of care and health need on medical care use among rural adolescents," *Archives of Pediatrics and Adolescent Medicine* 155(2):184-190 (2001), AC Beal, J Ausiello and J Perrin, "Social influences on health-risk behaviors among minority middle school students," *Journal of Adolescent Health* 28(6):474-480 (2001); JD Klein and KM Wilson, "Delivering quality care: Adolescents' discussion of health risks with their providers," *Journal of Adolescent Health* 30(3):190-195 (2002).
7. For example, the American Academy of Pediatrics and the American Medical Association. M Green and JS Palfrey, eds., *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (2nd ed., rev.), National Center for Education in Maternal and Child Health (2002).
8. P Newacheck et al., "Adolescent health insurance coverage: Recent changes and access to care," *Pediatrics* 104(2):195-202 (1999), C Schoen et al., *The Health of Adolescent Boys: Commonwealth Fund Survey Findings*, The Commonwealth Fund (1998); CA Ford, PS Bearman and J Moody, "Foregone health care among adolescents," *Journal of the American Medical Association* 282(23): 2227-2234 (1999); Children Now, *Partners in Transition: Adolescents and Managed Care* (2000); JD Klein et al., "Access to medical care for adolescents: Results from the 1997 Commonwealth Fund survey of the health of adolescent girls," *Journal of Adolescent Health* 25(2): 120-130 (1999).
9. For a review of the literature, see Hadley, J. (2002). *Sicker and Poorer: The Consequences of Being Uninsured*. Chapter 6 – "Insurance, Medical Care Use, and Birth, Child, and Maternal Health Outcomes." Prepared for the Kaiser\ Commission on Medicaid and the Uninsured. http://www.kff.org/content/2002/20020510//(see Chapter 6, pp 53-71).
10. *Health Insurance is a Family Matter*. (2002). National Academies Press, Washington, DC. http://www.nap.edu/books/0309085187/html
11. D. Cohen Ross and I.T. Hill, "Enrolling Eligible Children and Keeping Then Enrolled," *The Future of Children* 13 (Spring 2003). Available at http://www.futureofchildren.org/usr_doc?tfoc131j.pdf. and D.C. Hughes and S. Ng, "Reducing Health Disparities Among Children," *The Future of Children* 13 (Spring 2003). Available at http://www.futureofchildren.org/usr_doc/foc121j.pdf
12. Child Trends DataBank, *Percentage of Children Covered by Health Insurance, by Type of Insurance, Selected Years*, 1987-2003.
13. (Source: Child Trends DataBank, *Percentage of Children Covered by Health Insurance, by Race and Hispanic Origin*, 2003.)
14. Child Trends DataBank, *Health Care Coverage* Fact Sheet, 2003.
15. Child Trends DataBank, *Health Care Coverage* Fact Sheet, 2003.
16. Child trends DataBook, *Percentage of Children Under 18 Who Are Covered By Health Insurance. All Health Insurance (Private and Government)*, 1987-2003.
17. *Tennessee Medicaid Facts*, American Academy of Pediatrics website, August 2003
18. *Tennessee: Distribution of Children 18 and Under by Insurance Status, state data 2002 2003, U.S. 2003*, Kaiser Family Foundation, www.statehealthfacts.org.)
19. Ibid.
20. U.S. Census Bureau, *Low Income Uninsured Children by State: 2001, 2002, and 2003. (Three year averages)*.
21. 2006 MCH Block Grant Application, Form 11, National Performance measure #13.
22. CMS- 416 Report, FFY 2004.
23. Centers for Medicaid and Medicare, Form 416, *Annual EPSDT Participation Report, Tennessee FY: 2003*.
24. Tennessee Bureau of TennCare website as of July 22, 2005.

http://www.state.tn.us/tenncare/.
25. Centers for Medicaid and Medicare, Form 416, *Annual EPSDT Participation Report, Tennessee FY: 2003*
26. Center for Medicaid and Medicare, EPSDT website, as of July 22, 2005.
27. Tennessee Department of Health, TENNderCARE Outreach Program
28. Tennessee Department of Health, TENNderCARE Outreach program, July 2005.
29. Bureau of TennCare web site as of 7-18-05.
30. Tennessee Department of Health, Patient Tracking Billing Management and Information System (PTBMIS), July 2005.
31. HB Fox, MA McManus, and SJ Limb, *Access to Care for S-CHIP Adolescents*, Kaiser Commission on Medicaid and the Uninsured (2000); National Conference of State Legislatures, Health Policy Tracking Service, *Mental Health Coverage in Title XXI Plans* (1999); L Ku, F Ullman and R Almeida, *What Counts? Determining Medicaid and CHIP Eligibility for Children*, Urban Institute (1999); T Brown, *The Impact of the State Children's Health Insurance Program (SCHIP) on Title V Children with Special Health Care Needs Programs – Updated Edition*, The Association of Maternal and Child Health Programs (2000)
32. See Klein et al., "Access to medical care," see note 8; see also, e.g., Klein and Wilson, "Delivering quality care," see note 6; AV Marcell et al., "Male adolescent use of health care services: Where are the boys?" *Journal of Adolescent Health* 30(1): 35-43; The Center for Reproductive Rights (formerly the Center for Reproductive Law and Policy), *Restrictions on Young Women's Access to Abortion Services* (2002) and *Parental Consent and Notice for Contraceptives Threatens Teen Health and Constitutional Rights* (2001)
33. Notwithstanding confidentiality requirements in law, the Society for Adolescent Medicine position paper on confidentiality includes the statement: "Blind adherence to absolute confidentiality, or absence of confidentiality (in deference to parental wishes), is neither desirable nor required by ethics or law." "Confidential health care for adolescents: A position paper of the Society for Adolescent Medicine," *Journal of Adolescent Health* 21:408-415 (1997).
34. See, e.g., National PTA, *Healthy Children, Successful Students: Comprehensive School Health Programs (no date).*
35. Children Now, *Partners in Transition: Adolescents and Managed Care* (2000). Partners in Transition provides an overview of the barriers that prevent teens from receiving the health care they need and spotlights health plans from across the country that have successfully addressed them. The report includes eleven strategies, each of which is illustrated by a model program. See also National Adolescent Health Information Center, *Assuring the Health of Adolescents in Managed Care: A Quality Checklist for Planning and Evaluating Components of Adolescent Health Care* (1998).
36. DC Ross and M Booth, *Enrolling Children in Health Coverage Programs: Schools Are Part of the Equation*, Covering Kids and the Center on Budget and Policy Priorities (2001).
37. Division of Adolescent and School Health, *Coordinated School Health Program* (2002).
38. Ibid.
39. See, generally, the Center for Health and Health Care in Schools, *School-Based Health Centers – Background* (no date); National Assembly on School-Based Health Care, *Partners in Access: School-Based Health Centers and Medicaid – Policies and Practices* (2001).
40. See, e.g., DW Kaplan et al., "Managed care and school based health centers: Use of health services," *Archives of Pediatrics and Adolescent Medicine* 152(1): 25-33 (1998). For an extensive bibliography on school-based health, from the National Center for Health and Health Care in Schools, go to: http://www.healthinschools.org/sbhcs/biblio.asp.
41. Colorado Association for School-Based Health Care, *What is a School-Based Health Center?* and *1999 Annual Report.*
42. The National Center for Health and Health Care in Schools, *Children's Mental Health Needs, Disparities and School-Based Services:*

A Fact Sheet (no date).

43. National Assembly of School-Based Health Care website as of July 21, 2005, www.nasbhc.org)
44. S Silow-Carroll et al., *Reaching Out: Successful Efforts to Provide Children and Families with Health Care*, Community Voices: Healthcare for the Underserved, WK Kellogg Foundation (2002).
45. See, e.g., the following references, broken down by subject: Age: LE Conard, JD Fortenberry and DP Orr, "Pharmacists' attitudes and practices with adolescents," *Journal of Adolescent Health* 30(2): 93-94 (2002); Foster Care: DW Nelson, "Gratified but not satisfied on foster care independence," *AdvoCasey* 3(2), Annie E. Casey Foundation (2001); HN Taussig, RB Clyman and J Landsverk, "Children who return home from foster care: A 6-year prospective study of behavioral health outcomes in adolescence," *Pediatrics* 108(1): e10 (2001); Gender: J *Falling through Cracks for Sexual Health Care*, Advocates for Youth (2001); Race/Ethnicity: Advocates for Youth, *Effective HIV/STD and Teen Pregnancy Prevention Programs for Young Women of Color* (2001); Transition: RW Blum et al., "Transition from child-centered to adult health-care systems for adolescents with chronic conditions: A position paper of the Society for Adolescent Medicine," *Journal of Adolescent Health* 14:570-576 (1993); Juvenile Justice: JJ Cocozza and K Skowyra, "Youth with mental health disorders in the juvenile justice system: Issues and emerging responses," *Juvenile Justice* 7(1): 3-14, Office of Juvenile Justice and Delinquency Prevention (2000); Youth with Special Health Care Needs: LA Smith, PH Wise and NS Wampler, "Knowledge of welfare reform program provisions among families of children with chronic conditions," *American Journal of Public Health* 92(2): 228-230 (2002).
46. See, e.g., JW Noell and LM Ochs, "Relationship of sexual orientation to substance use, suicidal ideation, suicide attempts, and other factors in a population of homeless adolescents," *Journal of Adolescent Health* 29(1): 31-36; Advocates for Youth, *Lesbian, Gay, Bisexual, and Transgender Youth: At Risk and Underserved* (1998); N Seiler, TANF and *Teen Parents with Disabilities*, Center for Law and Social Policy (2001).
47. CD Brindis et al., *Improving Adolescent Health: An Analysis and Synthesis of Health Policy Recommendations*, National Adolescent Health Information Center (1997).